APPLICATION FOR APPROVED PROVIDER OR AFFILIATE PROVIDER, EVALUATORS AND EMERITUS PROVIDERS FOR SEX OFFENDER OUTPATIENT SERVICES

Name: _____ Date: _____

Agency/Clinic Affiliation (if any): _____

Agency/business owner: _____

Address of agency: _____

City, State and Zip code: _____

Email: _____ Phone: _____

Is applying for status indicated below, as given recognition by the Utah Department of Corrections: (Check the one that applies)

☐ Approved Provider

☐ Approved Affiliate Provider

☐ Approved Evaluator

☐ Approved Emeritus Provider

APPROVED <u>PROVIDER</u> APPLICANTS the following is required:

- Read and agree to the UDC (Utah Department of Corrections) Sex Offender Outpatient Treatment Provider Parameters.
- Enclose a complete program description.
- Submit a completed application.
- Get your application notarized. This will serve as the prior certificate of compliance.
- Enclose the Approved Provider/Affiliate agreement.

APPROVED <u>AFFILIATE</u> PROVIDER APPLICANTS the following is required:

- Read and agree to the UDC (Utah Department of Corrections) Sex Offender Outpatient Treatment Provider Parameters.
- Enclose a complete program description.
- Submit a completed application.
- Get your application notarized. This will serve as the prior certificate of compliance.
- Enclose the Approved Provider/Affiliate agreement.

APPROVED PROVIDER FOR <u>EVALUATIONS</u> ONLY:

- **<u>MUST</u>** be a Psychologist and can skip numbers 3 – 5, while abiding by APA ethics and standards.

1) Licensure: _____
(Attach a photo-copy of current Utah license(s)

2) Educational Background (Graduate only): _____
_____
_____

3) Non-Licensed Affiliate Candidates: Describe your current status that qualifies your application for an Affiliate Provider as per the Utah Department of Corrections professional qualification found in the Sex Offender Outpatient Treatment Provider Parameters: _____
_____
_____

4) Affiliate Applicant: Attach copies of a current graduate student university transcript and/or an internship transcript or other official documentation from your University clearing documenting your status.

5) Approved Provider only – not required for affiliate status: Hours of direct clinical experience over the past 2 years to include a minimum of 1000 hours, with 180 hours of sex offender evaluation experience. This should be direct evaluation experience such as: supervision exclusively focused on sex offender assessment or evaluation; progress reports; progress interviews; administration and/or interpretation of risk assessment instruments; PPG, and other psychological or sex-specific testing utilized in a psycho-sexual evaluation. The treatment of evaluations experience should be document below. Source documentation must be available for inspection upon request. PLEASE NOTE: Progress notes and clinical staff meeting will **not** be including in the area of sex offender evaluation experience.

Sex offender treatment experience (a minimum of 1000 hours)

A) Number of hours providing specific sex offender individual treatment _____

B) Number of hours providing specific sex offender group treatment _____

C) Number of hours providing specific sex offender psycho educational classes _____

D) Other (please specify the activity and number of hours _____

_____

_____

Sex offender evaluation experience (a minimum of 180 hours)

A) Number of hours providing psychosexual/documentation evaluations _____

B) Number of hours administering risk assessments (STATIC99, STABLE 2007, SOTIPS, etc.)/interpretation/documentation _____

C) Number of hours providing specific sexual interest/deviant arousal evaluations/interpretation/documentation _____

D) Number of exclusively focused sex offender treatment supervision _____

E) Other (please specify psychological or sex specific testing, administration, interpretation, documentation and number of hours _____

_____

_____

6) Within three (3) years immediately preceding the application for approval as a Sex Offender Treatment Provider, the applicant has at least twenty six (26) hours of formal training through documented conferences, symposia, seminars or course work **directly related to the evaluation and treatment of sex offenders.**

Said training may include behavioral/cognitive therapy methods, reconditioning and relapse prevention, use of plethysmograph examinations (the exam should use audio stimuli only, no visual, until approved otherwise), use of polygraph examinations, group therapy, sexual dysfunction, victimology, couples and family therapy, risk assessment, sexual addiction, sexual deviancy, and ethics and professional standards. Nineteen (19) of these twenty six (26) hours **must** be sex offender treatment specific.

Please detail compliance with the requirements contained in paragraph number two by specifically identifying the date, sponsor, subject matter, location and number of hours for each training session. Attach records documenting compliance, where available.

SEX OFFENDER SPECIFIC TRAINING:

Date	Sponsor	Subject	Location	CEU's

TOTAL SEX OFFENDER CEU'S _____

GENERAL CLINICAL TRAINING:

Date	Sponsor	Subject	Location	CEU's

TOTAL GENERAL CLINICAL CEU'S (7 HOURS MAY BE APPLIED TO THE 26 HOURS OF REQUIRED TRAINING): _____

(Please attach verification of formal training. Use additional sheets as needed.)

7) Please attach a complete description of your treatment program, clearly identifying the intake, standard and intensive components, aftercare and therapeutic approaches (e.g., CBI, Good Lives, etc). Please also attach some examples of curriculum, assignments for psycho-education lessons, group one-on-ones, etc.

8) Please list any criminal convictions, licensing actions, ethical questions or complaints: _____

_____

_____

_____

9) Affiliate Provider candidates, please complete sections **A** and **B**. Providers proceed to number 10.

A) Name of Approved Provider supervising work: _____

B) Please have your Approved Provider read and sign the following statement:

I certify that I am an Approved Provider for Outpatient Sex Offender Treatment for offenders under the supervision of the Utah Department of Corrections, Division of Field Operations and have read and understand the criteria adopted by the Division. I further certify that I will provide a minimum of one hour of supervision for every forty hours of direct client contact the Affiliate Provider shall provide. Furthermore, I shall provide verification of this supervision to the Department upon request.

_____ _____

Approved Provider Signature supervising the Affiliate Provider — Date

_____ _____

Signature of Affiliate Provider applicant — Date

10) I hereby declare under the penalty of perjury that the information I have provided in this certification is true and correct and that I have fully satisfied the sex offender treatment experience and training requirements outlined in paragraphs 5) and 6) above.

Dated this _____ (day), _____ (month) and _____ (year).

Applicant's Signature: _____

Applicant's Full Name: _____

State of Utah
County of _____

Subscribed and sworn to before me on this _____ (day) _____ (month) and _____ (year).

Notary Signature: _____

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